Expanding Medicaid to the New Adult Group through Section 1115 Waivers

After the June 2012 U.S. Supreme Court ruling in *NFIB v. Sebelius* effectively made Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) optional for states, a number of states have considered alternative approaches to extending coverage to previously ineligible adults.[1] As of August 2016, 31 states and the District of Columbia, have expanded Medicaid to previously ineligible adults and six of these states—Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire—are currently providing Medicaid to the expansion population through Section 1115 research and demonstration waivers.[2] Pennsylvania also expanded Medicaid through a waiver from January 1 through August 31, 2015; however, the state transitioned to a traditional expansion effective September 1, 2015.[3]

Section 1115 waivers allow states to test additional features that are not allowed under traditional Medicaid, such as the imposition of higher cost sharing for some enrollees and placing limitations on certain mandatory benefits. While each of the waivers is unique, there are some common themes. This issue brief summarizes the main design features of expansion waivers currently in operation, including benefits, premiums and cost sharing, premium assistance, and the delivery system. (For more details on the waivers, see Table 1 and state-specific fact sheets.)

Populations Covered

The ACA expanded Medicaid coverage to non-elderly adults without dependent children with incomes at or below 138 percent of the federal poverty level (FPL), and parents with incomes above pre-ACA eligibility thresholds, but at or below 138 percent FPL. Although the law required all states to cover these adults, in June 2012, the U.S. Supreme Court ruled that the expansion mandate could not be enforced by withholding funds for a state's entire program, effectively making the expansion optional.

Each of the states with approved waivers use them to cover the new adult group. In Indiana, premium and cost sharing requirements under the waiver also apply to other eligibility groups. In Indiana and New Hampshire, some are instead enrolled in the states' employer premium assistance program and are receiving coverage through a cost-effective employer plan with premiums paid by Medicaid.[4]

Benefits

Medicaid enrollees who are in the new adult group must receive the alternative benefit plan (ABP), a benchmark plan modeled on commercial insurance coverage rather than the traditional Medicaid benefit plan.[5] Individuals who are medically frail are exempt from mandatory enrollment in the ABP if it does not include all of the benefits provided under the Medicaid state plan.[6] The ABP must cover certain services, such as family planning services and supplies, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age

21. It also must comply with mental health parity rules and provide the ten essential health benefits also required in exchange plans (42 CFR 440.345 and 42 CFR 440.347).

Several of the states receiving waivers have sought to exclude certain benefits (although not all of the proposed exclusions were approved), and most of the approved exclusions do not involve a substantial change in benefits. Specifically, Indiana and Iowa are not providing non-emergency medical transportation (NEMT) in the first year of their waivers; Arkansas requires prior authorization for NEMT. In Arkansas and New Hampshire, which provide premium assistance (discussed below), Medicaid must provide benefits that are not otherwise available in the plans these states purchase on behalf of Medicaid beneficiaries. For example, these states provide EPSDT services to 19- and 20-year-olds as wrap-around services under their Medicaid fee-for-service delivery systems.

Unlike the other waiver states, the terms of Indiana's waiver do not obligate it to provide retroactive coverage during the first year of the demonstration. However, Indiana does have a waiver-required transition program, effective for a minimum of one year, for certain low-income parents and caretakers, which reimburses providers for services furnished within 90 days prior to the effective date of eligibility, and collects data to evaluate whether there are gaps in coverage. New Hampshire has a provisional waiver of retroactive coverage, conditioned upon data demonstrating that the state system ensures that enrollees do not have periods when they have no coverage.

Premiums and Cost Sharing

Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, copayments, or other cost sharing amounts, although federal guidelines specify who may be charged these fees, the services for which they may be charged, and the allowed amounts. Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services, such as emergency services. States also may not charge premiums for enrollees with income at or below 150 percent FPL. All cost sharing (including premiums and per-service charges) incurred by members of a family is subject to an aggregate limit of five percent of the family's income (42 CFR 447.50-447.56).

The states with approved waivers sought changes to the premium and cost sharing schedules so that all enrollees pay something, even nominally, toward the cost of coverage.[7] For example, all waivers require some level of copayment and Iowa, Michigan, and Montana charge monthly premiums. In Montana, premium payments are credited toward the enrollee's first 2 percent of copayments. Additionally, Arkansas, Indiana, and Michigan use an approach similar to a health savings account in which enrollees make monthly or quarterly contributions toward payment for services. Iowa, Indiana, and Michigan also provide credits or discounts on premiums or health savings account contributions based on the completion of certain healthy behavior requirements, such as getting a risk assessment or annual wellness exam.[8]

Under all of these waivers, enrollees remain protected by the Medicaid rule limiting aggregate out-of-pocket spending to 5 percent of income. Additionally, while premiums may be charged to enrollees with incomes below 100 percent FPL, they are not at risk of losing their Medicaid coverage for nonpayment; however, in Indiana, Iowa, and Montana, enrollees with incomes above 100 percent FPL can lose coverage for non-payment of premiums. In Indiana, these individuals can be denied reenrollment for six months, in Montana enrollees are able to re-enroll

once they pay overdue premiums or their premium debt is assessed against their state taxes, and in Iowa, individuals can reenroll at any time.

Premium Assistance

Premium assistance is the state purchase of private market plans, such as through an employer-sponsored plan or a plan on a health insurance exchange, on behalf of Medicaid enrollees. Three of the waiver states are using some type of premium assistance in their expansions (Iowa had been using premium assistance, but is now covering all enrollees through managed care).[9] In Arkansas and New Hampshire, adults are enrolled in exchange plans. Beginning in 2018, individuals in Michigan will have the choice of enrolling in Medicaid or an exchange plan. In Indiana and New Hampshire, new adult group enrollees also may be enrolled in cost-effective employer-sponsored coverage in premium assistance arrangements.[10]

Delivery System

States either offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or through some combination of the two. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. Indiana, Iowa, and Michigan's waivers provide services through managed care plans for new adult group enrollees. Arkansas and New Hampshire's premium assistance programs provide benefits through exchange plans with the Medicaid fee-for-service program providing wrap-around benefits. Montana contracts with a third-party administrator for the delivery and fee-for-service payment of health care services for most adults in the new group with incomes between 50 and 138 percent FPL.

Conclusion

Six states are currently operating Section 1115 waivers to implement Medicaid expansion. While the terms of each state's waiver vary, the waivers generally do not involve a substantial change in benefits compared to those offered in Medicaid. Although all states are charging some level of cost sharing, it is still subject to the five percent of income cap and enrollment of individuals with incomes below 100 percent FPL cannot be contingent on payment of premiums. Four states are using some sort of premium assistance.

Because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation. As such, each of these varied approaches to coverage for the new adult group may provide data on the effect of changes in benefits and cost sharing on enrollment, access to care, and service use, which can serve to inform policy. However, data will not be available on the full extent of the waivers for several years.

Table 1. Summary of Provisions Waived in Approved Section 1115 Medicaid Expansion Waivers

State	Benefits	Premiums and cost sharing	Premium assistance for enrollment	Delivery system
Arkansas	None	Individual accounts with monthly contributions for enrollees >100% FPL; co-pays for those who don't contribute	Exchange plans	Exchange plans, with fee-for-service (FFS) wrap
Indiana	Non-emergency medical transportation (NEMT) waived in first year	Individual accounts for all enrollees; co-pays for those ≥ 100% FPL who don't contribute; graduated co-pay for non-emergency use of the emergency department (ED)	Employer-sponsored insurance	Managed care
Iowa	NEMT waived in first year and has been extended	Premiums for enrollees >50% FPL; premiums waived for healthy behaviors; disenrollment for non-payment of premiums for enrollees >100% FPL; co-pay for non-emergency use of the ED	None; previously used employer-sponsored insurance and exchange plan premium assistance for certain populations	Managed care
Michigan	None	All enrollees subject to co-payments; premiums for enrollees >100% FPL; payments go toward a health account; credits for healthy behaviors	Exchange plans (beginning in April 2018)	Managed care
Montana	None	Monthly premiums for enrollees > 50% FPL that are credited toward co-payments	None	FFS, administered by third party administrator
New Hampshire	None	Co-payments for enrollees >100% FPL	Exchange plans; employer-sponsored insurance premium assistance offered through a separate state program	Exchange plans, with FFS wrap

Endnotes

[1] *NFIB v. Sebelius*, 567 U.S. ___ (2012), 132 S.Ct 2566.

[2] A Section 1115 waiver gives broad authority to the Secretary of Health and Human Services to authorize an experimental, pilot, or demonstration project that is likely to assist in promoting the objectives of a state's Medicaid program. Section 1115 waivers allow the Secretary to waive certain provisions of the Medicaid statutes related to state program design, and are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state.

[3] Pennsylvania received approval for a five-year waiver called Healthy Pennsylvania, which began enrolling individuals on January 1, 2015. Healthy Pennsylvania provided coverage to enrollees through Medicaid managed care. Outside of the demonstration, the state planned to encourage employment through job training and work-related activities. However, a new governor was elected in November 2014 who took action to end the waiver and transition the state to a traditional Medicaid expansion, halting the implementation of some waiver activities that were to begin in the second year of the waiver and rolling back waiver activities that had already begun. The transition was fully implemented on September 1, 2015 (Office of Governor Tom Wolf 2015).

[4] Cost effectiveness for premium assistance means that the total cost of purchasing premium assistance coverage, including administrative expenditures, the costs of paying all excess cost sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing traditional coverage under the state plan (42 CFR 435.1015(a)(4)).

[5] An alternative benefit plan (ABP) offers an option to states to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups or provide services through specific delivery systems, instead of following the traditional Medicaid benefit plan. All states that expand Medicaid are required to submit an ABP to denote any differences in benefit coverage between the base population and expansion population, or to note that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

[6] Most other exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage); because medically frail individuals do not become eligible for Medicaid through a separate pathway, they are most likely to be enrolled in the new adult group. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical of mental disability that significantly impairs their ability to perform one or more activities of daily living, or other special medical needs (42 CFR 440.315(f)).

[7] Under Section 1115 authority, the Secretary can waive premium requirements; however Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

[8] Indiana's waiver also mentions the use of healthy behavior incentives, but no further details are provided.

[9] Iowa previously operated two waivers for the new adult group: Marketplace Choice which utilized premium assistance to purchase exchange plans for individuals in the new adult group with incomes between 100 and 138 percent FPL and the Wellness Plan which provided coverage through managed care for those with incomes below 100 percent FPL. On December 24, 2015, the state received approval to enroll individuals in the Marketplace Choice waiver in the Wellness Plan. This waiver does not utilize premium assistance.

[10] Cost effectiveness for premium assistance means that the total cost of purchasing coverage is comparable to the cost of providing traditional Medicaid coverage. See footnote 4.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Section 1115 of the Social Security Act Medicaid demonstration: Technical corrections from amendment to the Iowa Wellness Plan. February 23. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Section 1115 of the Social Security Act Medicaid demonstration: Montana Health and Economic Livelihood Partnership (HELP) program. November 2, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. New Hampshire Health Protection Program Premium Assistance. March 4. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Healthy Indiana Plan (HIP) 2.0. January 27. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to the Arkansas Health Care Independence Program (Private Option). December 31. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Section 1115 of the Social Security Act Medicaid demonstration: Healthy Michigan Section 1115 Demonstration. December 31. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to the Iowa Marketplace Choice Plan. December 30. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.

Office of Governor Tom Wolf, State of Pennsylvania. 2015. Pennsylvania transition final 79,272 individuals into expanded Medicaid program. July 27, 2015, press release. https://governor.pa.gov/pennsylvania-transitions-final-79272-individuals-into-expanded-medicaid-program/.